

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043968

Facility Name: ASTA CARE CENTER OF PONTIAC

Address: 300 WEST LOWELL PONTIAC 61764
Number City Zip Code

County: LIVINGSTON

Telephone Number: (815) 842-1181 Fax # (815) 842-3406

IDPA ID Number: 36-4228801

Date of Initial License for Current Owners: 08/17/98

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
IRS Exemption Code		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
		<input checked="" type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input type="checkbox"/>	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) MICHAEL GILLMAN
(Title) PRESIDENT

Paid
Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date) _____
(Print Name and Title) BOB KAGDA PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC

0043968 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>80</u>	Intermediate (ICF)	<u>80</u>	<u>29,200</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>80</u>	TOTALS	<u>80</u>	<u>29,200</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>16,516</u>	<u>10,833</u>		<u>27,349</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,516</u>	<u>10,833</u>		<u>27,349</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 93.66%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?

YES

☐

NO

☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

☐

NO

☒

I. On what date did you start providing long term care at this location?

Date started

08/17/98

J. Was the facility purchased or leased after January 1, 1978?

YES

☒

Date 08/17/98

NO

☐

K. Was the facility certified for Medicare during the reporting year?

YES

☐

NO

☒

If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	156,953	10,940	7,808	175,701		175,701	0	175,701			1
2	Food Purchase		113,383		113,383		113,383	(4,271)	109,112			2
3	Housekeeping	85,986	13,793	0	99,779		99,779	0	99,779			3
4	Laundry	53,475	19,374	338	73,187		73,187	0	73,187			4
5	Heat and Other Utilities			66,153	66,153		66,153	0	66,153			5
6	Maintenance	23,629	8,859	24,020	56,508		56,508	1,584	58,092			6
7	Other (specify):*			6,287	6,287		6,287	0	6,287			7
8	TOTAL General Services	320,043	166,349	104,606	590,998	0	590,998	(2,687)	588,311			8
	B. Health Care and Programs											
9	Medical Director	0		6,500	6,500		6,500	0	6,500			9
10	Nursing and Medical Records	727,898	53,695	175,980	957,573		957,573	0	957,573			10
10a	Therapy	0	555	0	555		555	0	555			10a
11	Activities	101,481		2,544	104,025		104,025	0	104,025			11
12	Social Services	22,485		2,101	24,586		24,586	0	24,586			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			0	0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	851,864	54,250	187,125	1,093,239	0	1,093,239	0	1,093,239			16
	C. General Administration											
17	Administrative	57,420		172,200	229,620	(8,700)	220,920	(136,995)	83,925			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			14,280	14,280	8,700	22,980	6,604	29,584			19
20	Dues, Fees, Subscriptions & Promotions			56,303	56,303		56,303	(39,468)	16,835			20
21	Clerical & General Office Expenses	62,423	4,146	33,392	99,961		99,961	60,122	160,083			21
22	Employee Benefits & Payroll Taxes			193,801	193,801		193,801	0	193,801			22
23	Inservice Training & Education			5,698	5,698		5,698	0	5,698			23
24	Travel and Seminar			0	0		0	53	53			24
25	Other Admin. Staff Transportation			7,762	7,762		7,762	4,526	12,288			25
26	Insurance-Prop.Liab.Malpractice			37,025	37,025		37,025	2,799	39,824			26
27	Other (specify):*			1,752	1,752		1,752	6,579	8,331			27
28	TOTAL General Administration	119,843	4,146	522,213	646,202	0	646,202	(95,780)	550,422			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,291,750	224,745	813,944	2,330,439	0	2,330,439	(98,467)	2,231,972			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			20,218	20,218		20,218	95,493	115,711			30
31	Amortization of Pre-Op. & Org.			927	927		927	0	927			31
32	Interest			22,209	22,209		22,209	154,344	176,553			32
33	Real Estate Taxes			38,125	38,125		38,125	0	38,125			33
34	Rent-Facility & Grounds			205,185	205,185		205,185	(205,185)	0			34
35	Rent-Equipment & Vehicles			3,354	3,354		3,354	718	4,072			35
36	Other (specify):* amort-comp. Soft.			2,382	2,382		2,382	6,221	8,603			36
37	TOTAL Ownership			292,400	292,400	0	292,400	51,591	343,991			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		2,877	47,036	49,913		49,913	0	49,913			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			43,800	43,800		43,800	0	43,800			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	2,877	90,836	93,713	0	93,713	0	93,713			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,291,750	227,622	1,197,180	2,716,552	0	2,716,552	(46,876)	2,669,676			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,675)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(1,561)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,149)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	0	21		18
19	Entertainment	0	20		19
20	Contributions	(1,960)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,752)	27		24
25	Fund Raising, Advertising and Promotional	(37,777)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule <u>SEE PAGE 5A</u>	(1,661)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (50,535)		\$ 0	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	3,659		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 3,659		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (46,876)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	<u>Gift and Coffee Shops</u>					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$ 1584	6	1
2	DISCOUNTS	(1,561)	2	2
3	MARKETING DIRECTOR	(1,684)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,661)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC

0043968

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,271)	0	0	0	0	0	0	0	0	0	0	(4,271)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	1,584	0	0	0	0	0	0	0	0	0	0	1,584	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,687)	0	0	0	0	0	0	0	0	0	0	(2,687)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(136,995)	0	0	0	0	0	0	0	0	0	(136,995)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,355	2,249	0	0	0	0	0	0	0	0	6,604	19
20	Fees, Subscriptions & Promotions	(39,737)	269	0	0	0	0	0	0	0	0	0	(39,468)	20
21	Clerical & General Office Expenses	(1,684)	61,806	0	0	0	0	0	0	0	0	0	60,122	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	53	0	0	0	0	0	0	0	0	0	53	24
25	Other Admin. Staff Transportation	0	4,526	0	0	0	0	0	0	0	0	0	4,526	25
26	Insurance-Prop.Liab.Malpractice	0	2,799	0	0	0	0	0	0	0	0	0	2,799	26
27	Other (specify):*	(1,752)	8,331	0	0	0	0	0	0	0	0	0	6,579	27
28	TOTAL General Administration	(43,173)	(54,856)	2,249	0	0	0	0	0	0	0	0	(95,780)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(45,860)	(54,856)	2,249	0	0	0	0	0	0	0	0	(98,467)	29

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	\$ 205,185			\$	(205,185)	15
16	V	19	PROFESSIONAL FEES		ASTA PONTIAC PROPERTIES		2,249	2,249	16
17	V	30	DEPRECIATION		ASTA PONTIAC PROPERTIES		96,595	96,595	17
18	V	32	INTEREST		ASTA PONTIAC PROPERTIES		154,322	154,322	18
19	V	36	AMORT.-MORT. COSTS		ASTA PONTIAC PROPERTIES		6,221	6,221	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 205,185			\$ 259,387	\$ * 54,202	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MICHAEL GILLMAN	25	LIST ATTACHED		ASTA HEALTH-CARE COMPANY	ELGIN	MANAGEMENT
DARRYLE GILLMAN	25					
BARRY KIRSCHENBAUM	25					
DIANE KIRSCHENBAUM	25			ASTA PONTIAC PROPERTIES	ELGIN	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	\$ 163,500	ASTA HEALTHCARE COMPANY		\$	\$ (163,500)	1
2	V								2
3	V	17	OFFICER SALARIES				26,505	26,505	3
4	V	19	PROFESSIONAL FEES				4,355	4,355	4
5	V	20	DUES, FEES,SUBSCRIPTIONS				269	269	5
6	V	21	OFFICE EXPENSES				61,806	61,806	6
7	V	27	EMPLOYEE BENEFITS				8,331	8,331	7
8	V	24	EDUCATION & SEMINARS				53	53	8
9	V	25	TRANSPORTATION STAFF				4,526	4,526	9
10	V	26	GENERAL INSURANCE				2,799	2,799	10
11	V	30	DEPRECIATYION				3,573	3,573	11
12	V	32	INTEREST EXPENSE				22	22	12
13	V	35	EQUIPMENT RENT				718	718	13
14	Total			\$ 163,500			\$ 112,957	\$ * (50,543)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3		SEE ATTACHED									3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization ASTA HEALTHCARE COMPANY
Street Address 134 N. MCLEAN BLVD.
City / State / Zip Code ELGIN, IL 60123
Phone Number (847) 742-8822
Fax Number (847) 742-9013

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICER SALARIES	PATIENT DAYS	154,774	5	\$ 150,000	\$ 150,000	27,349	\$ 26,505	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	154,774	5	24,648		27,349	4,355	2
3	20	DUES, FEES,SUBSCRIPTIONS	PATIENT DAYS	154,774	5	1,525		27,349	269	3
4	21	OFFICE EXPENSES	PATIENT DAYS	154,774	5	349,775	319,993	27,349	61,806	4
5	27	EMPLOYEE BENEFITS	PATIENT DAYS	154,774	5	47,148		27,349	8,331	5
6	24	EDUCATION & SEMINARS	PATIENT DAYS	154,774	5	300		27,349	53	6
7	25	TRANSPORTATION STAFF	PATIENT DAYS	154,774	5	25,616		27,349	4,526	7
8	26	GENERAL INSURANCE	PATIENT DAYS	154,774	5	15,832		27,349	2,799	8
9	30	DEPRECIATION	PATIENT DAYS	154,774	5	20,218		27,349	3,573	9
10	32	INTEREST EXPENSE	PATIENT DAYS	154,774	5	124		27,349	22	10
11	35	EQUIPMENT RENT	PATIENT DAYS	154,774	5	4,066		27,349	718	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 639,252	\$ 469,993		\$ 112,957	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	AMERICAN NAT'L BANK		X	MORTGAGE	\$17,099.00	8/17/98	\$ 2,075,000	\$ 1,923,628	8/17/03	0.0780	\$ 154,322	1	
2												2	
3												3	
4												4	
5	RELATED PARTY										22	5	
	Working Capital												
6	AMERICAN NAT'L BANK		X	WORKING CAPITAL	INTEREST	LOC	150,000	400,000	REVOLV	PRIME+	19,046	6	
7	CAPITAL ALLIANCE		X	VAN PURCHASE	\$831.00	05/15/99	31,200	12,652	06/15/03	0.1133	1,834	7	
8	INSURANCE POLICIES		X								1,329	8	
9	TOTAL Facility Related					\$17,930.00		\$ 2,256,200	\$ 2,336,280			\$ 176,553	9
	B. Non-Facility Related*												
10	IRS, IDR, ETC		X	LATE FEES								10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related							\$ 0	\$ 0			\$ 0	14
15	TOTALS (line 9+line14)							\$ 2,256,200	\$ 2,336,280			\$ 176,553	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASTA CARE CENTER OF PONTIAC COUNTY LIVINGSTON

FACILITY IDPH LICENSE NUMBER 0043968

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2000

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	15-15-27-255-001	NURSING HOME	\$ 37,071.94	\$ 37,091.74
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 37,071.94	\$ 37,091.74

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,600 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☒ YES ☐ NO
If so, please complete the following:

1. Total Amount Incurred: 4,636 2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 927 4. Dates Incurred: 08/17/98

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

		1	2	3	4	
A. Land.		Use	Square Feet	Year Acquired	Cost	
1		<u>0</u>			\$ <u>100,000</u>	1
2						2
3	TOTALS				\$ <u>100,000</u>	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	85		1998	1961	\$ 1,438,473	\$ 52,308	27.5	\$ 52,308	\$	\$ 176,539	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LAND IMPROVEMENTS - PURCHASE ALLOCATION(PROP)			1998	97,058	6,471	27.5	6,471		21,839	9
10	WATER HEATERS & PLUMBING (PROP)			1999	14,502	527	27.5	527		1,339	10
11	BOILER & A/C (PROP)			1999	14,240	518	27.5	518		1,316	11
12	ELECTRONIC DOOR LOCKS (PROP)			1999	3,974	145	27.5	145		368	12
13	FENCE (PROP)			1999	1,155	77	15	77		196	13
14	REMODELING ROOMS & BATHROOMS (PROP)			2000	47,944	1,743	27.5	1,743		2,687	14
15	AIR CONDITIONER (PROP)			2000	5,569	203	27.5	203		313	15
16	FIRE PANEL (PROP)			2000	2,730	99	27.5	99		639	16
17	FURNISHING			2000	2,839	695	7	695		609	17
18	WATER SOFTENER (PROP)			2001	4,013	79	27.5	79		79	18
19	CONDENSER (PROP)			2001	3,100	61	27.5	61		61	19
20	HEATER/AC UNITS (PROP)			2001	5,100	100	27.5	100		100	20
21	GREASE TRAP (PROP)			2001	1,300	26	27.5	26		26	21
22	3 DOORS (PROP)			2001	4,000	79	27.5	79		79	22
23	FENCE (PROP)			2001	2,564	92	15	92		92	23
24	SIDEWALK (PROP)			2001	1,850	67	15	67		67	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,650,411	\$ 63,290		\$ 63,290	\$ 0	\$ 206,349	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 61,500	\$ 10,942	\$ 6,150	\$ (4,792)	10	\$ 12,200	71
72	Current Year Purchases	1,516	303	76	(227)	10	76	72
73	Fully Depreciated Assets				0			73
74	RELATED PARTY	340,000	37,573	37,573	0	10	113,333	74
75	TOTALS	\$ 403,016	\$ 48,818	\$ 43,799	\$ (5,019)		\$ 125,609	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY VAN	1999 FORD ELD. VAN	1999	\$ 43,112	\$ 8,278	\$ 8,622	\$ 344	5	\$ 21,555	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 43,112	\$ 8,278	\$ 8,622	\$ 344		\$ 21,555	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,196,539	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 120,386	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 115,711	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (4,675)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 353,513	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
- If NO, see instructions.
- YES
- NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- YES
- NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- YES
- NO
16. Rental Amount for movable equipment: \$
- 3,354
- Description:
- SEE SCHEDULE ATTACHED
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
- Beginning
- Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	\$
13.	/2003	\$
14.	/2004	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

COMMUNITY COLLEGE☐

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

HOURS PER AIDE

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$		\$	0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 18,544	\$		\$ 18,544	1
2	Licensed Speech and Language Development Therapist	10-3	hrs			2,166			2,166	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs			26,142			26,142	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				2,877		2,877	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					184			184	13
14	TOTAL			\$		\$ 47,036	\$ 2,877		\$ 49,913	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 159,861	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	298,523		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,943		6
7	Other Prepaid Expenses	2,527		7
8	Accounts Receivable (owners or related parties)	32,244		8
9	Other(specify): <u>REAL ESTATE ESCROW</u>	28,643		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 530,741	\$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	118,493		16
17	Accumulated Depreciation (book methods)	(79,719)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	4,636		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(3,133)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 40,277	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 571,018	\$ 0	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 151,163	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,925		29
30	Accrued Salaries Payable	33,721		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,186		31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,072		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 230,067	\$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	412,652		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 412,652	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 642,719	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ (71,701)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 571,018	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 21,341	1
2	Restatements (describe):		2
3	ROUNDING	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 21,343	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	26,956	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(120,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (93,044)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (71,701)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,652,684	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,652,684	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	84,716	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 84,716	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 0	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	ADJUSTMENT OF PRIOR YEARS EXPENSE	4,547	28
28a	DISCOUNTS EARNED	1,561	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,108	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,743,508	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	590,998	31
32	Health Care	1,093,239	32
33	General Administration	646,202	33
	B. Capital Expense		
34	Ownership	292,400	34
	C. Ancillary Expense		
35	Special Cost Centers	49,913	35
36	Provider Participation Fee	43,800	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,716,552	40
41	Income before Income Taxes (line 30 minus line 40)**	26,956	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 26,956	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,916	2,157	\$ 49,764	\$ 23.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,515	5,796	106,644	18.40	3
4	Licensed Practical Nurses	9,393	9,607	160,731	16.73	4
5	Nurse Aides & Orderlies	42,959	43,804	388,210	8.86	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,331	2,569	32,764	12.75	9
10	Activity Assistants	10,020	10,677	68,717	6.44	10
11	Social Service Workers	1,964	2,011	22,485	11.18	11
12	Dietician					12
13	Food Service Supervisor	1,965	2,150	24,293	11.30	13
14	Head Cook	8,094	8,592	65,117	7.58	14
15	Cook Helpers/Assistants	9,176	9,774	67,543	6.91	15
16	Dishwashers					16
17	Maintenance Workers	2,026	2,050	23,629	11.53	17
18	Housekeepers	12,145	12,516	85,986	6.87	18
19	Laundry	5,822	6,735	53,475	7.94	19
20	Administrator	2,029	2,086	57,420	27.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,705	5,256	62,423	11.88	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,020	2,333	22,549	9.67	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	122,080	128,113	\$ 1,291,750 *	\$ 10.08	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 7,245	1-3	35
36	Medical Director	O	6,500	9-3	36
37	Medical Records Consultant	N	1,200	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	0	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,290	11-3	44
45	Social Service Consultant	E	2,101	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 18,336		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,505	\$ 59,832	10-3	50
51	Licensed Practical Nurses	1,450	57,062	10-3	51
52	Nurse Aides	1,993	46,660	10-3	52
53	TOTAL (lines 50 - 52)	4,948	\$ 163,554		53

XIX. SUPPORT SCHEDULES

[illegible]

*** Attach copy of IMRF notifications**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	6/00	\$ 9,939	3	\$	\$	\$ 1,657	\$ 3,313	\$ 3,313	\$ 1,656	\$	\$	\$
2	PAINT/DECORATING	6/01	2,075	3				346	692	692	345		
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 12,014		\$	\$	\$ 1,657	\$ 3,659	\$ 4,005	\$ 2,348	\$ 345	\$	\$

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC

0043968

Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL HEALTH CARE ASSOC. \$ 4560
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 519 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 43,800
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	7,245
	REPAIRS & MAINTENANCE	563
		0
		7,808
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	338
		0
		338
5	HEAT & OTHER UTILITIES	
	GAS HEAT	13,210
	ELECTRICITY	35,792
	WATER	17,151
	CABLE TV - LOBBY	0
		0
		66,153
6	MAINTENANCE	
	GROUNDS MAINTENANCE	4,524
	PAINTING & DECORATING	2,075
	BUILDING REPAIRS	4,042
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	6,985
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	573
	EXTERMINATING SERVICE	1,157
	FIRE SERVICE	3,583
	COST REBILLED - SALARIES	1,081
		0
		24,020
7	OTHER	
	SCAVENGER	5,597
	SECURITY SERVICE	690
		6,287
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,500
		6,500

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	163,554
	LABORATORY & XRAY EXPENSE	987
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B -2	2,230
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,200
	PHARMACY CONSULTANT XVIII B 39-2	0
	UTILIZATION REVIEW FEES XVIII B -2	494
	PHYSICIANS XVIII B -2	0
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	0
	PROGRAM CONSULTANT	6,101
	DENTAL	1,414
		175,980
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B -2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,290
	ACTIVITY PROGRAM EXPENSE	1,254
		2,544
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	949
	SOCIAL WORKER XVIII B 45-2	1,152
		0
		2,101
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	0	0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 172,200	172,200
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 3,853	
	ADMINISTRATIVE CONSULTANTS	XIX C 0	
	PROFESSIONAL FEES	XIX C 10,427	
		0	14,280
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 37,777	
	EMPLOYEE WANT ADS	XIX F 8,826	
	CONTRIBUTIONS	VI 20 XIX F 1,960	
	DUES & SUBSCRIPTIONS	XIX F 5,704	
	LICENSES & PERMITS	XIX F 1,022	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 1,014	56,303
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES	401	
	EQUIPMENT REPAIR & MAINTENANCE	4,040	
	OUTSIDE CLERICAL SERVICES	0	
	PENALTIES / OVERDRAFT CHARGES	VI 18 0	
	HOME OFFICE EXPENSE	11,229	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	16,459	
	MESSENGER SERVICE	124	
	CABLE TV	1,139	33,392

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 96,801	
	UNEMPLOYMENT COMPENSATION	XIX D 9,624	
	WORKERS COMPENSATION INSURANC	XIX D 34,000	
	HOSPITALIZATION INSURANCE	XIX D 40,536	
	EMPLOYEE BENEFITS - OTHER	XIX D 5,243	
	EMPLOYEE PHYSICAL EXAMS	XIX D 720	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 0	
	PENSION/PROFIT SHARING PLANS	XIX D 6,877	
	CHICAGO HEAD TAX	XIX D 0	193,801
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	5,698	5,698
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 0	
	TRAVEL	XIX G 0	
		0	
		0	0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	7,762	7,762
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	37,025	37,025
27	OTHER		
	BAD DEBTS	VI 24 1,752	
			1,752

GRAND TOTAL COLUMN 3 OTHER

813,944

ASTA CARE CENTER OF PONTIAC
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	113,383	PATIENT MEALS	82047
LESS SALES TAX	1,149	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	112234	TOTAL MEALS/YEAR	82047
TOTAL PATIENT CENSUS	27,349	NET FOOD	112234
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	82047

TOTAL PATIENT MEALS	82047	COST PER MEAL	1.37
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		